by covered entities under the Health Insurance Portability and Accountability Act (HIPAA) and related CMS manual instructions. When a paper RA is mailed, it must comply with CMS manual instructions that parallel the HIPAA data content and coding requirements.

(2) The notice of initial determination must contain:

(i) The basis for any full or partial denial determination of services or items on the claim;

(ii) Information on the right to a redetermination if the provider or supplier is dissatisfied with the outcome of the initial determination;

(iii) All applicable claim adjustment reason and remark codes to explain the determination;

(iv) The source of the RA and who may be contacted if the provider or supplier requires further information;

(v) All content requirements of the standard adopted for national use by covered entities under HIPAA; and

(vi) Any other requirements specified by CMS.

§ 405.922 Time frame for processing initial determinations.

The contractor issues initial determinations on clean claims within 30 days of receipt if they are submitted by or on behalf of the beneficiary who received the items and/or services; otherwise, interest must be paid at the rate specified at 31 U.S.C. 3902(a) for the period beginning on the day after the required payment date and ending on the date payment is made.

§ 405.924 Actions that are initial determinations.

(a) *Applications and entitlement of individuals.* SSA makes initial determinations and processes reconsiderations with respect to an individual on the following:

(1) A determination with respect to entitlement to hospital insurance or supplementary medical insurance under Medicare.

(2) A disallowance of an individual's application for entitlement to hospital or supplementary medical insurance, if the individual fails to submit evidence requested by SSA to support the application. (SSA specifies in the initial determination the conditions of entitlement that the applicant failed to establish by not submitting the requested evidence).

(3) A denial of a request for withdrawal of an application for hospital or supplementary medical insurance, or a denial of a request for cancellation of a request for withdrawal.

(4) A determination as to whether an individual, previously determined as entitled to hospital or supplementary medical insurance, is no longer entitled to those benefits, including a determination based on nonpayment of premiums.

(b) *Claims made by or on behalf of beneficiaries.* The Medicare contractor makes initial determinations regarding claims for benefits under Medicare Part A and Part B. A finding that a request for payment or other submission does not meet the requirements for a Medicare claim as defined in § 424.32 of this chapter, is not considered an initial determination. An initial determination for purposes of this subpart includes, but is not limited to, determinations with respect to:

(1) If the items and/or services furnished are covered under title XVIII;

(2) In the case of determinations on the basis of section 1879(b) or (c) of the Act, if the beneficiary, or supplier who accepts assignment under § 424.55 of this chapter knew, or could reasonably have expected to know at the time the items or services were furnished, that the items or services were not covered;

(3) In the case of determinations on the basis of section 1842(l)(1) of the Act, if the beneficiary or physician knew, or could reasonably have expected to know at the time the services were furnished, that the services were not covered;

(4) Whether the deductible is met;

(5) The computation of the coinsurance amount;

(6) The number of days used for inpatient hospital, psychiatric hospital, or post-hospital extended care;

(7) The number of home health visits used;

(8) Periods of hospice care used;

(9) Requirements for certification and plan of treatment for physician services, durable medical equipment, therapies, inpatient hospitalization,